Hoffman Behavioral Health

Client Information

Today's Date: _____

Name: _____

Street address: _____ City: _____State:___Zip:_____

Primary Phone #: _____Type: cell home work Msg. OK?: ◯ Yes ◯ No

Alternative Phone #: _____Type: cell home work Msg. OK?: ◯ Yes ◯ No

E-mail: _____Msg OK: ◯ Yes ◯ No

Emergency Contact: _____ Relationship to you: _____ Phone#:_____

Who referred you? _____ What is your relationship with this person? _____

May I contact this person to thank him or her for referring you? ◯ Yes ◯ No

If you were not referred how did you find about me? _____

DOB:_____ Age: _____ Gender: _____ Sexual Orientation: _____

Please describe your ethnic, cultural, religious and or spiritual practice background: _____

Highest grade or level of education: _____ Current occupation:_____

Relationship:

single partnered married separated divorced widowed other: _____

Please briefly describe what brought you to therapy:

_____

_____

_____

Have you ever been in therapy before? ◯ Yes ◯ No If yes, please list: (include name and dates)

_____

_____

_____

Previous psychiatric hospitalizations or intensive outpatient treatment? ◯ Yes ◯ No If yes, please list.

_____

Have any family members been diagnosed or treated for mental health conditions? ◯ Yes ◯ No If yes, please list family members and conditions. _____

_____

Do you currently consume alcohol? ◯ Yes ◯ No

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If yes, list average number of drinks per occasion: _____ frequency/days per week: _____

What is the maximum amount of drinks consumed during one occasion in the past year?: _____

Do you have any concerns about your alcohol or substance use? ◯ Yes ◯ No

Have family members or friends expressed concern about your drinking? ◯ Yes ◯ No

Any previous treatment for alcohol or substance use/abuse? ◯ Yes ◯ No

Is there any alcohol or substance use in your home now that concerns you? ◯ Yes ◯ No

Was there any alcohol or substance use in your home growing up that concerned you? ◯ Yes ◯ No

Do you have a history of problematic use of prescription /non-prescription drugs? ◯ Yes ◯ No

Have you ever had thoughts of wanting to end your life? ◯ Yes ◯ No If yes, when? _____

Have you ever attempted to harm yourself? ◯ Yes ◯ No If yes, when? _____

Have you had serious thoughts of harming another person? ◯ Yes ◯ No If yes, when? _____

Is there any violence or other abuse in your home that concerns you? ◯ Yes ◯ No

Was there any violence or other abuse in your home growing up? ◯ Yes ◯ No

Are there any firearms in your current place of residence? ◯ Yes ◯ No

Have you ever been convicted of a crime? ◯ Yes ◯ No

Are you currently involved in or do you anticipate involvement in legal proceedings? ◯ Yes ◯ No

Name of Primary Care Physician: _____Clinic Name: _____

Phone # for PCP: _____Last Physical: _____

Current health concerns or illnesses (include allergies):

_____

_____

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Past medical problems and surgeries:

_____

Are you on any psychiatric medication? ◯ Yes ◯ No If yes, please list include dosage.

_____

Have you previously been prescribed psychiatric medication? ◯ Yes ◯ No If yes, please list.

_____

Are you taking any other kinds of medication or vitamins? ◯ Yes ◯ No If yes, please list dosage and reason.

_____

Describe your sleep (how many hours, night waking, difficulty falling asleep):

_____

Have you gained or lost weight without trying in the last six months? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No If yes, please describe type and frequency.

_____

Do you drink caffeine? ◯ Yes ◯ No If yes, please describe type and frequency.

_____

Do you smoke cigarettes? ◯ Yes ◯ No If yes, how many cigarettes do you smoke per week? _____

Did you smoke cigarettes in the past? ◯ Yes ◯ No

Please list your immediate family members/significant persons (including parents, siblings, children, partner):

Name:	Age:	Live with you	Relationship to you:
_____	_____	◯ Yes ◯ No	_____
_____	_____	◯ Yes ◯ No	_____
_____	_____	◯ Yes ◯ No	_____
_____	_____	◯ Yes ◯ No	_____
_____	_____	◯ Yes ◯ No	_____

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